

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown Rural
 City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 years
 Hospital, Institution, or street address where death occurred:
Hagerstown Rt. 4
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown Rural (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown RT. 4 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Merrill K. Baker

3. (b) Social Security Number

275-05-6865

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife Gladys Baker

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) November 4, 1915

8. AGE: Years 32 Months 8 Days 29 If less than one day

9. Birthplace Hagerstown Wash. Md. (Town, county, and state)

10. Usual occupation Manger

11. Industry or business Hamilton Jewlers

12. Name Chalice Baker

13. Birthplace Indiana

14. Maiden name Lula Kline

15. Birthplace Boonesboro Md.

16. Informant Gladys Baker

Address Hagerstown Rt. 4

17. Burial Date thereof August 6, 1948 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Aug. 6, 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 48 at 6:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 to July 6 1948

and that I last saw him alive on July 6 1948

Immediate cause of death Malignant melanoma with metastases to the lungs

Due to metastases - 8

Due to the lungs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. Hagerstown M.D.

Address Hagerstown Md. Date signed 8/6-48

Address

Date signed

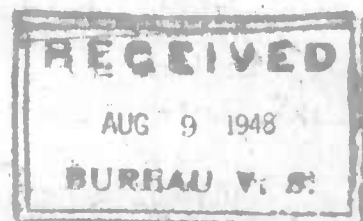
Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

08681

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Mins.
 Hospital, institution, or street address where death occurred:
Washington County Hospital.
 How long in hospital or institution? 10 Mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 440 George St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Henry Baker

3. (b) Social Security Number

219-01-7488

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife none
 7. Birth date of deceased (mo., day, yr.) June 19, 1912 8.(c) If alive, give age..... years
 8. AGE: Years 36 Months 2 Days 8 (If less than one day) hrs. min.

9. Birthplace Hagerstown, Washington, Maryland
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Md. Pipe & Metal Co.

12. Name Reuben L. Baker

13. Birthplace Security, Md.

14. Maiden name Alice Cordell

15. Birthplace Grimes Station, Md.

16. Informant Mrs. Alice Baker

Address 440 George St.

17. Burial Date thereof Aug. 30, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Aug. 28, 1948
 (Date rec'd by registrar) Registrar Blank Powers

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27-48 19 Aug 27-48 19

and that I last saw deceased Aug 27-48 19

Immediate cause of death..... DURATION

Cerebral Hemorrhage 1 1/2 hrs

Due to.....

Due to hypertension Cardio-vascular lesion 2 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

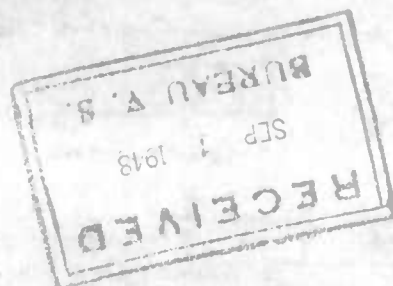
.....

.....

.....

23. SIGNATURE A. SW. [Signature] [Signature]
 M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 5 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. D. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Harry A. Barnhart

3. (b) Social Security Number

220-16-3595

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Eva E. Barnhart
 7. Birth date of deceased (mo., day, yr.) Sept. 5, 1876
 8. AGE: Years 71 Months 11 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Franklin County, Pa.
 (Town, county, and state)
 10. Usual occupation Farming
 11. Industry or business
 12. Name Harvey Barnhart
 13. Birthplace Maryland
 14. Maiden name Alice Pentz
 15. Birthplace Penna.

16. Informant Mrs. Eva E. Barnhart
 Address Hagerstown, Md. R D 2
 17. Burial Date thereof Aug. 8, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Cemetery
 Location Greencastle, Pa.
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. Aug. 7, 1948 Chas. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5, 1948 19. _____ at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 3 19. 46, to Aug 3 19. 48
 and that I last saw him alive on Aug 5 19. 48

Immediate cause of death Cerebral hemorrhage DURATION 87.745

Due to Hypertension ?
arteriosclerosis ?
 Due to Diabetes mellitus 1946

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE H. S. Porterfield M.D. M. D. or other
136 W Washington Address Date signed 8/6/48

RECEIVED

AUG 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

08683

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
410 Ridge Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 410 Ridge Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William E. Basore

3. (b) Social Security Number

717-07-9286

4. Sex Male 5. Color or race White 6.(a) Single, married, or divorced Married
 6.(b) Name of husband or wife Mabel V. (May) Basore
 6.(c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) Feb. 27 1900
 8. AGE: Years 48 Months 5 Days 15 It less than one day
 hrs. min.

9. Birthplace Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Rail Road

FATHER 12. Name Samuel E. Basore

13. Birthplace Washington Co. Md.

MOTHER 14. Maiden name Lucy E. Moor

15. Birthplace Washington Co. Md.

16. Informant Mabel V. Basore

Address 410 Ridge Ave. Hagerstown Md.

17. Burial Date thereof 8/15/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director C. L. Suman

Address 1025 Fairview Rd. Hagerstown Md.

19. Aug. 13, 48 Registrar Chas. H. Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12-48 9. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 12-48 to Aug 12-48

and that I last saw him alive on Aug 12-48 19.

Immediate cause of death

Hypertensive

Due to Cardio Vascular System 4 1/2

Due to Arterio-sclerotic

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. S. S. S. M. D. or other

Address Hagerstown Md. Date signed 12/1/48

RECEIVED

AUG 16 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08684

Reg. Dist. No. 302

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>52 years</u> Hospital, institution, or street address where death occurred: <u>122 Blossom Avenue</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>122 Blossom Avenue</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>World War I</u>			
3. (a) FULL NAME <u>Claude Bell</u>				3. (b) Social Security Number			
4. Sex <u>Male</u>		5. Color or race <u>Negro</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>			
6. (b) Name of husband or wife				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>February 9, 1892</u>				8. AGE: Years <u>56</u> Months <u>5</u> Days <u>24</u> If less than one day hrs. min.			
9. Birthplace <u>Beaver Creek, Wash., Md.</u> (Town, county, and state)				10. Usual occupation <u>Laborer</u>			
11. Industry or business				12. Name <u>Thomas F. Bell</u>			
13. Birthplace <u>Beaver Creek, Md.</u>				14. Maiden name <u>Mary Brown</u>			
15. Birthplace <u>Williamport, Md.</u>				16. Informant <u>Miss Nettie Bell</u> Address <u>52 W. Bethel Street.</u>			
17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>8/5/48</u> (month) (day) (year) Cemetery or crematory <u>Rose Hill Cemetery</u> Location <u>Hagerstown, Md.</u>				18. Funeral director <u>William H. Downey</u> Address <u>291 Frederick St Hagerstown</u> <u>Aug. 5, 1948</u> <u>Health Bowers</u> (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>AUGUST 2, 1948</u> at <u>6:55</u> A.M.							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>AUGUST 2, 1948</u> to <u>AUGUST 2, 1948</u> and that I last saw him alive on <u>AUGUST 2, 1948</u>							
Immediate cause of death <u>CORONARY OCCLUSION</u>							
DURATION							
Due to							
Due to							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Date of op.							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following:							
Accident, suicide, or homicide..... Date of							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>N. Alay Harris, M.D.</u> Address <u>651 Pennsylvania</u> Date signed <u>8/4/48</u> M. D. or other							

RECEIVED

AUG 7 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08685

Reg. Dist. No. 302

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Negro

Widow

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

48

11

11

..... hrs.

..... min.

9. Birthplace

Hagerstown, Washington, Md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date reg'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 21, 1948

at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 21, 1948, to Aug 21, 1948

and that I last saw him

dead on Aug 21, 1948

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

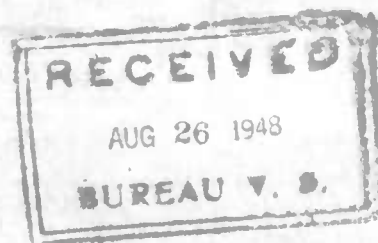
Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

100-10000-1000



RECEIVED
AUG 18 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs
 Hospital, institution, or street address where death occurred:
Maugansville Memorial Home
 How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Washington
 City or town Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

LEAH ESHLEMAN BOHN

3. (b) Social Security Number

4. Sex 7 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife William Bohn

7. Birth date of deceased (mo., day, yr.) Nov. 4. 1868

8. AGE: Years 79 Months 9 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Leitersburg MD (Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business Home

12. Name John Eshleman

13. Birthplace Penna

14. Maiden name Fannie Seacrist

15. Birthplace Franklin Co Pa

16. Informant Leslie Bohn

Address Wagoner Rd

17. (Burial, cremation, or removal which?) Date thereof Aug 31/48 (month) (day) (year)

Cemetery or crematory Reiff Cemetery

Location near Center

18. Funeral director A.E. Munnich

Address Greencastle Pa

19. Aug 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1948 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1948 to Aug 28 1948 and that I last saw him alive on Aug 1 1948

Immediate cause of death Carcinoma of Suprarenal Gland

Due to _____

Due to _____

Other conditions 0

(Include pregnancy within 3 months of death)

Major findings of operations 0

Date of op. _____

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date of _____

Where did injury occur? 0 (City or town) (County) (State)

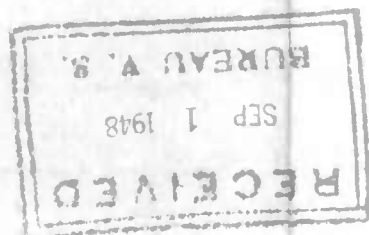
Injured at home, farm, industry, public place (where?) 0

Means of injury Injured at work?

23. SIGNATURE Victor D. Miller

Address 131 W. WASHINGTON, ST. M. D. or other Date signed 8/29/48

Alv Vic Miller
131 W. Washington St



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Bertha Sarah Ann Brady

3. (b) Social Security Number

none4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Earnest H. Brady7. Birth date of deceased (mo., day, yr.) Jan. 19th 18808. AGE: Years 68 Months 6 Days 21 If less than one day _____ hrs. _____ min.9. Birthplace London England
(Town, county, and state)10. Usual occupation Housekeeper

11. Industry or business

12. Name Surge Mitchell13. Birthplace London England14. Maiden name Bertha Wales15. Birthplace England16. Informant Alvin E. BradyAddress Hagerstown, Maryland17. Burial Date thereof 8/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Col. Suman Co. Ralph W. MartinAddress 1025 Fairview Rd. Hagerstown Md.19. Aug. 12, 1948 Charles Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1948 at 1:15 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1948 to August 10 1948and that I last saw him alive on August 19 1948

Immediate cause of death _____

Due to Carcinoma of duodenumand of stomach

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

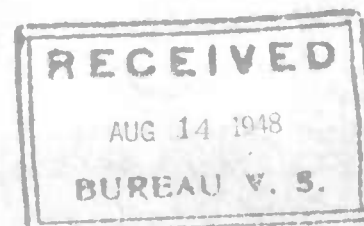
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE EW Llan M.D.Address Brownboro. Date signed 8/11/48

08688



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? one week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 136 N. Jonathan Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Maria Briscoe

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1894

8. AGE: Years 54 Months 4 Days 16 If less than one day hrs. min.

9. Birthplace Clearspring, Washington, Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name George Briscoe

13. Birthplace Clearspring, Md.

MOTHER 14. Maiden name Isabel Malson

15. Birthplace Clearspring, Md.

16. Informant Mrs. Matilda B. Johnson

Address 136 N. Jonathan Street

17. Burial Date thereof 8/30/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Wm. H. Brown

Address 291 Frederick, Hagerstown

19. Aug. 30, 48 Registrar Chas. H. Wood
 (Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 (26) 19 48 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 19 47 to Aug 26 19 48

and that I last saw her alive on Aug 26 19 48

Immediate cause of death Tubercular meningitis

Tuberculosis - 23rd Annual Report

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

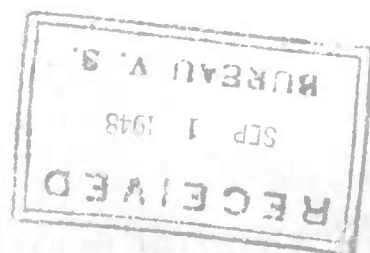
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip H. Nelson M. D. or other Hirshman

Address Hagerstown, Md. Date signed 8/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08690 301

1. PLACE OF DEATH:

County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 yearsHospital, institution, or street address where death occurred:
27 S. Conococheague St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. 27 S. Conococheague St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Brown

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Laura Davis Brown7. Birth date of deceased (mo., day, yr.) June 7, 18598. AGE: Years 89 Months 2 Days 22 It less than one day
.....hrs.min.9. Birthplace Bohemia, Europe
(Town, county, and state)10. Usual occupation Track Inspector (Retired)11. Industry or business Penna. R.R.12. Name Do not know13. Birthplace " " "14. Maiden name Do not know15. Birthplace " " "16. Informant Annie KrepsAddress Williamsport, Md.17. Burial Date thereof Sept. 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Otterbein CemeteryLocation Nr. Williamsport Falling Waters Rd18. Funeral director Edith V. LeafAddress Williamsport, Md.19. Sept. 1 19 48 E. L. McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/48 19 48 2:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/10/48 to 8/29/48and that I last saw him alive on 8/29/48 19 48Immediate cause of death Chronic Myocardial Disease

DURATION

3 wksDue to Fract. Rt. Hip 2 wks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: It death was due to external causes, fill in the following:

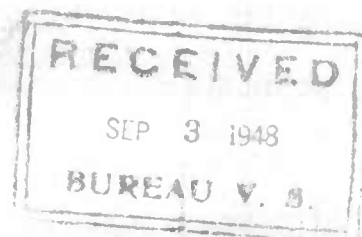
Accident, suicide, or homicide Accident Date of approx. 6 wks. agoWhere did injury occur? Williamsport (City or town) (County) (State)injured at home, farm, industry, public place (where?) Home 9/20/48Means of injury Fell down steps Injured at work?23. SIGNATURE P. P. Goring M. D. or otherAddress Williamsport, Md Date signed 9/31/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Washington Co. Hospital
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown R.F.D. 3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Leppans
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

Ida Kate Bussard

3. (b) Social Security Number

NO

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Zenas6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

May 18, 1883

8. AGE:

65

Years

Months

3

Days

19

If less than one day

hrs.

min.

9. Birthplace

Hagerstown, Md.
(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

Own HomeFATHER
MOTHER

12. Name

William Bower

13. Birthplace

Hagerstown, Md.

14. Maiden name

Sarah Bower

15. Birthplace

Hagerstown, Md.

16. Informant

Zenas H. Bower

Address

Hagerstown, R.F.D. 3 Md.

17. Burial

Date thereof Aug. 29/ 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Boardfaring Cemetery

Location

Near Boardfaring, Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown, Md.

19.

Aug. 28 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 26 19 48 at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 26 19 48 to Aug 26 19 48
and that I last saw him alive on Aug 26 19 48

Immediate cause of death

Uremia

DURATION

2 wks

Due to

Nephrosclerosis

Due to

Hypertensive cardio-vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

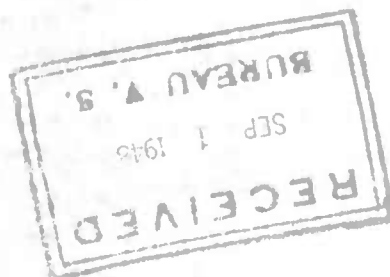
ROBERT F. KEADLE

132 W. WASHINGTON ST.
HAGERSTOWN, MARYLAND

M. D.

Date signed

8-27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 805 Forrest Drive
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

John E. Carey

3. (b) Social Security Number

170-09-0691

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Cecile F. Carey
 6. (c) If alive, give age 51 years
 7. Birth date of deceased (mo., day, yr.) August 21, 1894
 8. AGE: Years 53 Months 0 Days 15 If less than one day
 hrs. min.

9. Birthplace Boston, Mass.
 (Town, county, and state)
 10. Usual occupation Manager
 11. Industry or business Western Union Telegraph
 12. Name Charles Carey
 13. Birthplace Boston, Mass.
 14. Maiden name Alice English
 15. Birthplace Boston, Mass.

16. Informant Mrs. John E. Carey
 Address Hagerstown, Maryland
 17. Removal Removal Date thereof 8-9-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Holy Cross Cemetery
 Location Malden, Mass.

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Aug. 7, 1948 Registrar Shaft Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 1948 at 12 noon
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1, 1948 to Aug 6, 1948
 and that I last saw him alive on Aug 5, 1948

Immediate cause of death Myocardial Infarction with congestive failure
 DURATION 5 months

Due to Arteriosclerotic Heart Disease 3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE B. B. Schaefer, M.D.
 M. D. or other 1496 W. Washington St. Hagerstown, Md.
 Address Date signed 8-7-48

RECEIVED

AUG 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 08693 307

1. PLACE OF DEATH:

County Washington
 City or town Yarrowsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: Knoxville R.I.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Yarrowsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Knoxville md. R.I.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War One

3. (a) FULL NAME

Ernest Richard Carter Sr.

3. (b) Social Security Number

705-09-6499

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

William Redmon Carter

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 28 - 1895

8. AGE:

Years

Months

Days

If less than one day

5311

hrs.

min.

9. Birthplace

Yarrowsburg Wash. Co. md.
(Town, county, and state)

10. Usual occupation

Trainman

11. Industry or business

B. & O. R. B. Co.

MOTHER

12. Name

Isaac Carter

13. Birthplace

Wash. Co. md.

14. Maiden name

Mary Hoffmaster

15. Birthplace

Wash. Co. md.

16. Informant

Mrs. William Redmon Carter

Address

Knoxville md. R.I.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof Sept. 1, 1948
(month) (day) (year)

Cemetery or crematory

Church of the Brethren Cemetery

Location

Brownsville md.

18. Funeral director

Wm. J. Bant & Sons

Address

Brownsville md.

19.

Aug 31
(Date read by registrar)

19

48 Cornelia D. Castle
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August - 29 19 48 at..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July - 24 19 48, to Aug 29 19 48
and that I last saw him alive on Aug - 29 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 hrs

Due to

Hypertensive cardio-renal disease (?)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Bant

M. D. or other

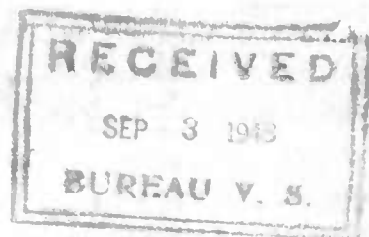
Address

Southville - Va.Date signed 8/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

7-9
 Carpenter
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08694

Reg. Dist. No. 302

1. PLACE OF DEATH:
 County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
Patterson Hotel, North Potomac St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Pennsylvania County Franklin
 City or town Greencastle
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. West Baltimore St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war non-vet. ✓

3. (a) FULL NAME NORMAN S. CLEVER
 3. (b) Social Security Number 184-07-4128

4. Sex Male
 5. Color or race White
 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 23, 1897

8. AGE: Years 51 Months 1 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Shippensburg, Franklin, Pa.
 (Town, county, and state)

10. Usual occupation Electrician

11. Industry or business Wiring

12. Name Edward Clever

13. Birthplace Shippensburg, Pa.

14. Maiden name Annie Naugle

15. Birthplace Shippensburg, Pa.

16. Informant George Clever
 Address Greencastle, Pa.

17. Burial Date thereof 8/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Greencastle, Franklin Co., Pa.

18. Funeral director A. E. Minnich

Address Greencastle, Pa.

19. Aug 27, 1948
 (Date rec'd by registrar) Registrar Black Hovers

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26-48 19____ at 3 _____ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 26-48 19____
 and that I last saw him dead on Aug 26-48 19____

Immediate cause of death _____

Crown Laceration

Due to _____

Due to _____

Other conditions _____

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
CERTIFICATE OF DEATH

RECEIVED

AUG 30 1948

BUREAU V. S.

RECEIVED

AUG 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08717

300

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Sharpsburg Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Sharpsburg Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

David W Clipp

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Ida M Clipp
 6.(c) If alive, give age 66 years
 7. Birth date of deceased (mo., day, yr.) Jan. 16 1872
 8. AGE: Years 76 Months 6 Days 15 If less than one dayhrs.min.

9. Birthplace Charlestown W.V.A.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farmer
 12. Name Charles W Clipp
 13. Birthplace Charlestown W.V.A.
 14. Maiden name Sarah Clipp
 15. Birthplace Charlestown W.V.A.
 16. Informant Herman W Clipp
 Address Sharpsburg Md.

17. Burial Date thereof Aug 17 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory W. Collins Cemetery
 Location Charlestown W.V.A.
 18. Funeral director Edith V Leaf
 Address Williamsport Md.

19. 8-16 48 Edith V Leaf
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 48 at 4:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13-48 19 Aug 13-48 19
 and that I last saw him dead on Aug 13-48 19
 Immediate cause of death

Crown Lesion DURATION 6 hrs
 Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Edith V Leaf (acting coroner)
 M. D. or other Physician
 Address Williamsport Md. Date signed 8-16-48

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

08718

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
220 North Potomac Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 220 North Potomac Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lillie May Cost

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Harvey A. Cost
 6. (c) If alive, give age 82 years
 7. Birth date of deceased (mo., day, yr.) January 22, 1872
 8. AGE: Years 76 Month 6 Day 22 If less than one day
hrs. min.

9. Birthplace Keedysville, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Frederick Wyand
 13. Birthplace Keedysville, Maryland
 14. Maiden name Lydia Ann Ecker
 15. Birthplace Keedysville, Maryland

16. Informant Harvey A. Cost
 Address Hagerstown, Maryland
 17. Burial 8-16-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Aug 16, 1948 Phyllis Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 48 at 7 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 48 to Aug 13 48
 and that I last saw Aug 13 48 alive on Aug 13 48
 Immediate cause of death

Cerebral Hemorrhage
 Due to 41 hr
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Phyllis Bowers M. D. or other
 Address Hagerstown Date signed Aug 16, 1948

RECEIVED

AUG 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08695

83a

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Pagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock Pagerstown Rural
 (If outside city or town limits, write RURAL and give nearest town)Street No. Washington County Home Unit

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Joshua Ditto Creager

3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
-----------------------	----------------------------------	---

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 25, 1867

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>2</u>	<u>15</u>	hrs. min.

9. Birthplace Washington County Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William J. Creager13. Birthplace Washington County Md.14. Maiden name Mary I. Creager15. Birthplace Washington County Maryland16. Informant Martha CreagerAddress Hancock, Maryland.17. Burial Date thereof Aug. 11, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Episcopal CemeteryLocation Hancock, Maryland18. Funeral director Snyder - Rowland Funeral HomeAddress Hancock, Maryland.19. Aug. 10, 48 Chas. H. Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 - 1948 at 5:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 - 1948 to Aug 9 - 1948and that I last saw him alive on Aug 5 - 1948

Immediate cause of death

Cerebral HemorrhageLeft sided Hemiplegia

Due to

Due to Arterio sclerosis -Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest J. PowersAddress Hagerston Md. Date signed 8/9/48

M. D. or other

RECEIVED

AUG 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
209 West Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 209 West Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Susan Fechtig Cushwa

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Monroe V. Cushwa
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) September 10, 1867
 8. AGE: Years 80 Months 10 Days 23 If less than one day... hrs. ... min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business Own Home
 12. Name George Fechtig
 13. Birthplace Hagerstown, Maryland
 14. Maiden name Harriet H. Doyle
 15. Birthplace Leitersburg, Maryland

16. Informant T. B. Cushwa
 Address Hagerstown, Maryland
 17. Burial Date thereof 8-6-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Aug. 4, 1948 Charles Bowen
 (Date rec'd. by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3-48 19... at 5:10 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-44 to 8-3-48
 and that I last saw him alive on 8-3-48 19...
 Immediate cause of death

Cerebral Vascular Disease 5 yrs
Ch. Arterio Sclerotic Heart 10 yrs
 Dura to...
 Dura to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. S. Suter M. D. or other
Charles Bowen Date signed 8-6-48
 Address

RECEIVED

AUG 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Breathsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route #3
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

John H. Daymude

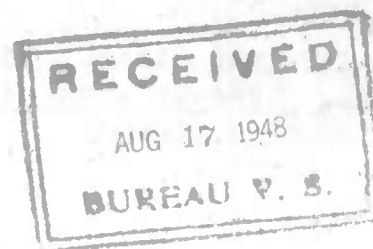
3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) December 25, 1899
 8. AGE: Years Months Days If less than one day
48 7 19 hrs. min.

9. Birthplace Hagerstown, Maryland
 (Town, county, and state)
 10. Usual occupation Coal-truck Driver
 11. Industry or business Steffey & Findlay Co.
 12. Name James H. Daymude
 13. Birthplace Virginia
 14. Maiden name Ella Cline
 15. Birthplace Frederick County, Maryland
 16. Informant Mrs. Florence Ahalt
 Address Hagerstown, Maryland
 17. Burial Date thereof 8-17-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland
 19. Aug 14 19 48 Breathsville
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 19 48 at 8 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13-48 19 Aug 13-48 19
 and that I last saw him dead on Aug 13-48 19
 Immediate cause of death.....
Ruptured Aorta
due to syphilis
confirmed by autopsy
 Other conditions Confirmed by autopsy
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE J. W. Suter M. D. or other
 Address Hagerstown Date signed Aug 14



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08721

83a

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Rural Boonsboro.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Boonsboro, Md. Route # 1
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Rural Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Route # 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

George Washington Domer

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Ada M. Kindall
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 16, 1868
 8. AGE: Years 80 Months 3 Days 15 If less than one day hrs. min.

9. Birthplace West Virginia
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business
 12. Name Unknown
 13. Birthplace
 14. Maiden name Unknown
 15. Birthplace

16. Informant Mr. George William Domer
 Address Boonsboro, Md. Route # 1
 17. Burial Date thereof Sept. 2, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Bakersville Cemetery
 Location Bakersville, Maryland
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland
 19. Sept. 2, 1948
 (Date rec'd by registrar) 19 48 John A. Bask
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948 19 48 3:55 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1948 to Aug. 31, 1948
 and that I last saw him alive on Aug. 31, 1948
 Immediate cause of death
Cerebral Hemorrhage
Arterial Hypertension
Gangrene
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

DURATION
1 Mo. 29
" "
10 days

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE John A. Bask M. D. on duty
 Address Boonsboro, Md. Date signed 9/1/48

RECEIVED

SEP 3 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

08722

Reg. Dist. No.

302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Pennsylvania County... Fulton
 City or town... Buck Valley Dist...
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

William Henry Dorrier

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife... Una Claubaugh Dorrier
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) March 17, 1875
 8. AGE: Years 73 Months 5 Days 4 If less than one day
 hrs. min.

9. Birthplace... Fulton County, Pa.
 (Town, county, and state)
 10. Usual occupation... Farming
 11. Industry or business
 12. Name... August Dorrier
 13. Birthplace... Fulton County, Pa.
 14. Maiden name... Matilda
 15. Birthplace... Fulton County, Pa.
 16. Informant... Mrs. Minnie Schultz,
 Address... Warfordsburg, Pa.
 17. Burial Date thereof... Aug. 24-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Mt. Pleasant Cemetery
 Location... Fulton County, Pa.
 18. Funeral director... Snyder-Rowland Funeral Home
 Address... Hancock, Maryland
 19. Aug. 24, 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH... August 21, 1948 19... 6:30 A. M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
17 August 1948 to 21 Aug 1948
 and that I last saw him alive on 20 August 1948
 Immediate cause of death... Fracture, neck of femur DURATION 4 days
 Due to...
 Due to...
 Other conditions... Hypertension, cardiac 1 year
vascular disease of acute 38 hrs
pneumonia (Include pregnancy within weeks of death)
 Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Accident Date of... 8/16/48
 Where did injury occur? Buck Valley (City or town) Penna. (County) (State)
 Injured at home, farm, industry, public place (where?) Home
 Means of injury... Stumbled over chair & fell Injured at work?
 23. SIGNATURE... W. J. Layman, M.D.
 Address... Hagerstown, Md Date signed... 21 Aug 1948

RECEIVED

AUG 26 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

08695

93d

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Dual Highway Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown Md. R.1.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No.

3. (a) FULL NAME

John Calvin Dubel

3. (b) Social Security Number

Unable to locate

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Minnie Dubel
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 24 - 1878
 8. AGE: Years 69 Months 10 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace New Myersville Fred. Co. Md.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Print. Farm12. Name Jacob Dubel13. Birthplace Wellsville Fred. Co. Md.14. Maiden name Charlotte Remue15. Birthplace New Myersville Fred. Co. Md.16. Informant Almy DubelAddress Boonsboro Md. R.117. Burial Date thereof Aug. 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Boonsboro CemeteryLocation Boonsboro Md.18. Funeral director Wm. J. Bart 930 AveAddress Boonsboro Md.19. Aug. 14 19 48 Chas. H. Mowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 48 at 4:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 48 to Aug 12 19 48 and that I last saw him alive on August 12 19 48

Immediate cause of death Pulmonary Edema
Cerebro vascular accident
(hemorrhage)
Hypertensive cardiovascular
disease
 Due to _____
 Due to _____
 Other conditions _____

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____Autopsy results Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert F. Keadle M. D. otherAddress 1324 W. Wash St. Date signed 8-12-48Address Hagerstown Md

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ine correct Page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1948

BUREAU V. S.

31

08697

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
City or town Rural Blue Ridge Summit, Pa.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

County Washington
City or town Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Blue Ridge Summit, Pa.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

John B. Eades

3. (b) Social Security Number

173-03-1934

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Eloise McKinley

7. Birth date of deceased (mo., day, yr.)

December 24, 1885

6. (c) If alive, give age

56 years

8. AGE:

Years

Months

Days

If less than one day

62714

hrs.

min.

9. Birthplace

Washington Co. Md.
(town, county, and state)

10. Usual occupation

General Manager

11. Industry or business

Feminine Fashion Inc.

MOTHER

FATHER

12. Name

Kellyam E. Eades

13. Birthplace

Washington Co. Md.

14. Maiden name

Susan Angli

15. Birthplace

Washington Co. Md.

16. Informant

Mrs. Eloise McKinley Eades

Address

Blue Ridge Summit, Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

8/11/48
(month) (day) (year)

Cemetery or crematory

Green Hill Cemetery

Location

Haymarket, Pa.

18. Funeral director

Walter J. Gove

Address

275 Church St. Haymarket, Pa.

19. Aug 9

19

48

Dr. W. Ferguson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 August 1948 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 August 1948 to 8 August 1948and that I last saw him alive on 7 August 1948

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Due to

Other conditions

Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert H. Ferguson, M.D.Address Blue Ridge Summit, Pa. Date signed 8 Aug 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town Boothsboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, institution, or street address where death occurred:
Guilford Convalescent Home
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Jacob Eavey

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Clarence Reedy Eavey

7. Birth date of deceased (mo., day, yr.) October - 21 - 1850 6. (c) If alive, give age 97 years

8. AGE: Years 97 Months 9 Days 24 If less than one day hrs. min.

9. Birthplace New Keedysville Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

12. Name Samuel Eavey

13. Birthplace Wash. Co. Md.

14. Maiden name Echer

15. Birthplace no Record

16. Informant E. L. Eavey

Address Keedysville Md

17. Burial Date thereof Aug. 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Ann's View Cemetery

Location Keedysville Md.

18. Funeral director W. J. Bart

Address Boothsboro Md.

19. August 17, 1948 John H. Bart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948 at 1:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1948 to Aug 15 1948 and that I last saw him alive on Aug 14 1948

Immediate cause of death Coronary Thrombosis
Arteriosclerosis

DURATION 8 Days
29 "

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert H. Bart M.D.
Address Boothsboro Md. Date signed 8/16/48

MARGIN RESERVED FOR BINDING

VS A15 9 45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wade

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Years

Hospital, institution, or street address where death occurred:

Guilford Nursing HomeHow long in hospital or institution? 2 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Park Road

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

MRS MARY ELIZA EDWARDS

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife William Henry Edwards6. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) November 30 18778. AGE: Years 70 Months 8 Days 11 If less than one day --- hrs. --- min.9. Birthplace Midway Jefferson Co. W. Va.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Anthony Crim13. Birthplace Midway W. Va.14. Maiden name Eugenia Crim15. Birthplace Midway W. Va.16. Informant W. Lee EdwardsAddress Hagerstown Md.17. Burial Date thereof 8/13/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug. 13, 1948 John H. Baer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948 19 48 at 3.30 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20th 1948 to Aug. 11th 1948
and that I last saw him alive on Aug. 10th 1948Immediate cause of death Uremia - Kidney complication
arterio-sclerosis
chronic arthritisDURATION
3 days
6 hrs.
6 mos.Due to Chronic ArthritisDue to Chronic ArthritisOther conditions Chronic Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations Chronic ArthritisDate of op. Chronic ArthritisAutopsy results Chronic Arthritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Chronic Arthritis Date of Chronic ArthritisWhere did injury occur? Chronic Arthritis (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Chronic ArthritisMeans of injury Chronic Arthritis Injured at work? Chronic Arthritis23. SIGNATURE Hubert Wade md

M. D. or other

Address Boonsboro Md. Date signed 8/13/48

RECEIVED
AUG 17 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

08701

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Breathedsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Mos 22 Days

Hospital, institution, or street address where death occurred:

Md. State Reformatory for MalesHow long in hospital or institution? 6 Mos 22 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Belt.City or town Baltimore 22

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Curtis Lane(If rural, give LOCATION) S. N 928 09 142.(a) If veteran, name war World War # 2 Navy

3. (a) FULL NAME

SAMUEL MCKINLEY FLIGGINS

3. (b) Social Security Number

416-20-7779

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary Lancaster6. (c) If alive, give age 20 years

7. Birth date of

deceased (mo., day, yr.)

December 23 1925

8. AGE:

Years

Months

Days

If less than one day

22723

hrs.

min.

9. Birthplace Baltimore Maryland

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
MOTHER12. Name Samuel Fliggins13. Birthplace Roanoke Va.14. Maiden name Annie Lee15. Birthplace Roanoke Va.16. Informant Files of the Md State reformatory for malesAddress Breathedsville Md17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 8/18/48

(month) (day) (year)

Cemetery or crematory Mount Calvary CemeteryLocation Baltimore, Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug. 16. 48 John H. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1948 at 2:10 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 1948 to Aug 16 1948and that I last saw him alive on Aug 15 1948

Immediate cause of death

DURATION

Pulm. Tuberculosis 6 mos.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D.Address Hagerstown, Md. Date signed 8-16-48

RECEIVED

AUG 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
Ravenwood Heights
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Ravenwood Heights
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary C. Fridinger

3. (b) Social Security Number

NONE

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 8.(b) Name of husband or wife..... William W. Fridinger 6.(c) If alive, give age..... 88 years
 7. Birth date of deceased (mo., day, yr.)..... September 1868
 8. AGE: Years..... 79 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Boonsboro, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....
 12. Name..... James Norris
 13. Birthplace..... Boonsboro, Maryland
 14. Maiden name..... Jane Lapole
 15. Birthplace..... Boonsboro, Maryland

16. Informant..... William W. Fridinger
 Address..... Hagerstown, Maryland
 17. Burial..... Date thereof..... 8-19-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Maryland
 18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Aug. 19, 1948
 (Date rec'd by registrar) Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 17 1948 at 3⁰⁰ P. M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
May 1948 to Aug 17 1948
 and that I last saw him alive on Aug 15 1948

Immediate cause of death.....
Carcinoma of sigmoid
 Due to..... Carcinoma of sigmoid
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... W. J. Layman M. D. or other.....
 Address..... Hagerstown Md. Date signed..... Nov 1948

RECEIVED

AUG 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF ~~Stillbirth~~ BIRTH

DEATH 08703
 Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

Child Lived One Hour

1. PLACE OF BIRTH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Washington County Hospital
 Length of mother's stay in County eight years
 (How many years, or months, or days SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 132 S. Locust St.
 (If RURAL give LOCATION)

3. Name of child Clarence William Sorsard Jr.

4. Date of birth Aug 4 1948 Hour 12:05 P.M.

5. Sex Male

6. Twin or triplet X

7. No. of weeks pregnancy 28 weeks

FATHER OF CHILD

MOTHER OF CHILD

8. Full name Clarence William Sorsard

12. Full maiden name Razel Malott

9. Color White 10. Age at time of this birth 30 yrs.

13. Color White 14. Age at time of this birth 30 yrs.

11. Usual occupation Contractor

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? None
 (b) How many other children were born alive but are now dead? None (c) How many other children were born dead? None

17. Did child die before labor? NO During labor? NO

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

18. Pregnancy, complications of yes
Prematurity - 7 mos

(a) Fetal causes Prematurity

19. Labor: (a) Complications of NO

(b) Maternal causes Prematurity

(b) Induced? NO

rupture of membranes

20. (a) Was there an operation for delivery? NO
 (Yes or No)

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

(b) State all operations, if any

Signature Albert L. Zief
 (Specify if M. D., midwife, or other)

(c) Did child die before operation?

Address Hagerstown MD

During operation?

23. (a) Burial (b) Date thereof Aug. 6, 1948
 (Burial, cremation or removal) (month) (day) (year)

25. (a) Aug 6, 1948 (b) Albert L. Zief
 (Date filed by registrar) (Registrar)

(c) Cemetery or crematory Rest Haven

24. (a) Funeral director Albert L. Zief

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

(b) Address Williamport, Ind.

Health Officer, per

* See Instruction C on stub.

RECEIVED

AUG 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08704

303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long is above place of death? 68 yrs.
 Hospital, institution, or street address where death occurred:
Main Street., Clearspring, Maryland.
 How long is hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County Washington
 City or town Clearspring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main Street.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Erma V. Gsell

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 8. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) October 7, 1878
 8. AGE: Years 69 Months 9 Days 26 hrs. min.
 9. Birthplace Franklin County, Penna.
 (Town, county, and state)
Home Duties
 10. Usual occupation
 11. Industry or business

12. Name Andrew Gsell
 13. Birthplace Franklin County, Penna.
 14. Maiden name Mary A. Brewer
 15. Birthplace Clearspring, Maryland.
 16. Informant P.S. Brewer Gsell
 Address Clearspring, Maryland.
 17. Burial Date thereof Aug. 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mennonite Cemetery
 Location Clearspring, Maryland
 18. Funeral director Snyder & Rowland.
 Address Clearspring, Maryland.
 19. Aug 4 19 48 Josephus Munn
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 19 48 at 6 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 48 to Aug 2 19 48
 and that I last saw her alive on July 28 19 48
 Immediate cause of death Coronary Thrombosis DURATION 2 years
Death sudden from
Coronary occlusion
 Due to
 Due to
 Other conditions Arterio Sclerosis 15 yrs.
 (Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D. M. D. or other
Clear Spring Md Address Date signed 8/4/48

RECEIVED

AUG 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Near Boonsboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2.
 How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Near Boonsboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 2.
 (If rural, give LOCATION)
 2(a) If veteran, name war No.

3. (a) FULL NAME

Jimmie Elizabeth

3. (b) Social Security Number

None.

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife David K. Griffith
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) February - 14 - 1892
 8. AGE: Years 56 Months 6 Days 0 If less than one day hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own Home.

FATHER 12. Name James Greenwalt
 13. Birthplace Fred. Co. Md.
 MOTHER 14. Maiden name Angie Munford
 15. Birthplace Fred. Co. Md.

16. Informant David K. Griffith
 Address Boonsboro Md. R. 2.

17. Burial Date thereof August 17, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery
 Location Boonsboro Md.

18. Funeral director Wm J. Bast & Sons
 Address Boonsboro Md.

19. August 17, 1948 John H. Bast
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 48 at 1:30 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 19 47 to Aug 14 19 48
 and that I last saw him alive on Aug 14 19 48

Immediate cause of death

Uremia; underlying cause

Due to

Malignant Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

SW Llan M.D.
 Address Boonsboro Date signed 8/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 19 1948

BUREAU V. O.

08706

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Ritchie Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Charlotte Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Dora Harrison

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Aug 26 1872 6.(c) If alive, give age _____ years

8. AGE: Years 75 Months 11 Days 8 It less than one day _____ hrs. _____ min.

9. Birthplace Charles Co. Md.
(Town, county, and state)

10. Usual occupation schoolteacher - retired

11. Industry or business _____

12. Name Philip Harrison

13. Birthplace St. Mary's Co. Md.

14. Maiden name Sarah A. Dent

15. Birthplace Kentucky

16. Informant Hosp. records

Address _____

17. Burial Date thereof 8-6-48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium All Faith

Location Charlotte Hall, Md.

18. Funeral director P. B. Robinson

Address Leonardtown, Md.

19. 8/6 1948 Cremation

(Date rec'd by registrar) Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1948 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1948 to Aug 3 1948
and that I last saw him alive on Aug 3 1948

Immediate cause of death Cerebral Hemorrhage DURATION 30 hrs

Due to Hypertensive, arterio-sclerotic Cardiovascular Disease?

Due to _____

Other conditions Arricular fibrillation?

Cardiac decompensation

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

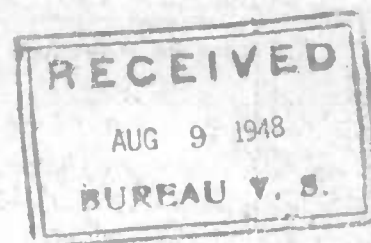
23. SIGNATURE J. M. Armstrong, M.D. M. D. or other _____

Address Ritchie Hospital Date signed 8/3/48
Cascade, Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... **X** Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
 Washington County Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 532 Salem Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Jacob L. Hartranft

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Annie E. Hartranft
 7. Birth date of deceased (mo., day, yr.) February 1, 1878
 6. (c) If alive, give age 63 years
 8. AGE: Years 70 Months 6 Days 13 hrs. min.

9. Birthplace Broadfording Was. Md.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business Farmer

FATHER 12. Name Aaron Hartranft
 13. Birthplace Lancaster Co. Pa.
 MOTHER 14. Maiden name Catherine Leshner
 15. Birthplace Wash. Co. Md.

16. Informant Mrs. Annie E. Hartranft
 Address Hagerstown Md.

17. Burial Date thereof August 17-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Grove Cemetery
 Location Franklin Co. Pa.
 18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. Aug 16, 48 Registrar
 (Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 48 9:40a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 48 to August 14 48
 and that I last saw him alive on August 14 48
 Immediate cause of death.....

Due to Cerebral thrombosis
 Arterio-sclerosis and
 vascular hypertension
 Due to Broncho pneumonia
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Autopsy results Cerebral arterial thrombosis - broncho pneumonia
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE.....
 Address Hagerstown Md.
 Date signed 8/14/48
 M. D. or other

08707

83b

302

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Keadle 08708

CERTIFICATE OF DEATH

Reg. Dist. No. 308

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Months
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Noah Roger Hines Jr.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

June 15 1948

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

033hrs.min.

9. Birthplace

Hagerstown Washington Co., Md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER
MOTHER

12. Name

Noah R. Hines

13. Birthplace

Hagerstown Md.

14. Maiden name

Thelma B. Draper

15. Birthplace

Smithsburg Md.

16. Informant

Noah R. Hines Sr.

Address

Hagerstown Md.

17. Burial

Date thereof 8/20/48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Pleasant Cemetery

Location

Near Smithsburg Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

Aug. 20 19 48
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 19 48 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 19 48 to August 18 19 48
 and that I last saw him alive on Aug 18, 1948

Immediate cause of death

Meningitis, type undetermined
 and meningovascular
 and hydrocephalus

DURATION

48 hrs
 life

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, pub'c place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE

Robert J. Keadle

M. D. or other

Address 1324 Wash St Date signed 8-19-48Hagerstown Md

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 23 1948

BUREAU W. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Mt. Sena - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R.2.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Mt. Sena - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R.2.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No.

3. (a) FULL NAME

Martha Vandella Hoffman

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Albert M. Hoffman
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April - 10 - 1885
 8. AGE: Years 63 Months 4 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Mt. Sena Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name William S. Lunn

13. Birthplace Mt. Sena Wash. Co. Md.

14. Maiden name Elizabeth Beachley

15. Birthplace Boonsboro Wash. Co. Md.

16. Informant Albert M. Hoffman

Address Boonsboro Md. R.2.

17. Burial Date thereof August 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Sena Cemetery

Location Mt. Sena Md.

18. Funeral director Wm. J. Bart & Sons

Address Boonsboro Md

19. August 15, 1948 John H. Bart
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1948 at 9:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
 and that I last saw him _____ alive on (read on arrival) _____ 19____

Immediate cause of death Acute Coronary Thrombosis
Chronic Myocarditis

DURATION

Bedden

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. Bart M. D. or other _____

Address Boonsboro Md. Date signed 8/14/48

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08710

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
City or town... near Hagerstown *carfax*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... one hour
Hospital, institution, or street address where death occurred:

How long in hospital or institution?... one hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Ohio County... Stark
City or town... Louisville
(If outside city or town limits, write RURAL and give nearest town)

Street No. ...
2. (a) If veteran, name war... *World War I*

3. (a) FULL NAME

Lester Edward Iler

3. (b) Social Security Number

297-05-1724

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Married

6. (b) Name of husband or wife... Thelma May

7. Birth date of deceased (mo., day, yr.)... June 29, 1895
8. (c) If alive, give age... 48 years

8. AGE: Years... 53 Months... 1 Days... 13 If less than one day... hrs. ... min.

9. Birthplace... Salem, Stark Co. Ohio
(Town, county, and state)

10. Usual occupation... Production Foreman
United Engineering & Foundry

11. Industry or business... Canton Ohio

12. Name... John Iler

13. Birthplace... Salem Ohio

14. Maiden name... Bertha Barnett

15. Birthplace... Salem Ohio

16. Informant... Mrs. Thelma May Iler
Address... Louisville Ohio

17. Removal... Date thereof... Aug. 12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... New Georgetown Cemetery

Location... New Georgetown Ohio

18. Funeral director... Schneeberger and Son

Address... Canton Ohio

19. Aug. 12 1948 *Charles Bowers*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Aug/11/48 EDT about 6P

21. I CERTIFY that death occurred on the date above related; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death... DURATION

Due to... Diabetes M 2yrs

Due to... acute coronary occlusion

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... *S. Robert Wells* WASH. CO., MD.

Address... Hagerstown, Md. Date signed... Aug 12 1948

RECEIVED

AUG 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH: Washington
 County.....
 City or town..... Hagerstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 83 years
 Hospital, institution, or street address where death occurred:
 Hagerstown Rt. 3
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Route 3
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Mary Jane Ilgenfritz

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Samuel Ilgenfritz

7. Birth date of deceased (mo., day, yr.) April 10, 1865 6. (c) If alive, give age..... years

8. AGE: Years 83 Months 3 Days 22 It less than one day..... hrs. min.

9. Birthplace Hagerstown Wash. Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name David T. Wolf

13. Birthplace Hagerstown Md.

14. Maiden name Rachael Hawthorne

15. Birthplace Hagerstown Md.

16. Informant Mrs. Howard Ilgenfritz
 Address Hagerstown Md.

17. Burial Date thereof August 5, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Hagerstown Md.
 Location.....

18. Funeral director Scott F. Minnix & Son
 Address Hagerstown Md.

19. Aug. 4, 1948 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1948, at 11:45p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946, to August 2, 1948
 and that I last saw him alive on August 2, 1948

Immediate cause of death Cerebral arteriosclerosis with mental deterioration DURATION 3 yrs

Due to.....
 Due to.....

Other conditions Arteriosclerosis Heart Disease with Auricular fibrillation (Include pregnancy within 8 months of death) DURATION 1 year

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Manner of injury Injured at work?

23. SIGNATURE Walter M. Welty M.D.
 M.D. or other
 Address Hagerstown, Maryland Date signed 8-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08712

93d

302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 years
 Hospital, institution, or street address where death occurred:
438 1/2 N. Jonathan Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 438 1/2 N. Jonathan
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Betty Ford Johnson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 12, 1862
 6. (c) If alive, give age..... years

8. AGE:

Years 86 Months 5 Days 10 If less than one day
 hrs. min.

9. Birthplace:

Charlestown Jefferson, W. Va.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date recorded by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

AUGUST 22, 1948 at 7:45 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 20, 1948, to August 22, 1948
 and that I last saw him alive on August 21, 1948

Immediate cause of death

CORONARY ARTERIOSCLEROTIC
HEART DISEASE

DURATION

UNDET.

Due to

HYPERTENSION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

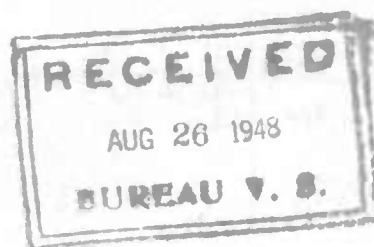
N. Alay Harris MD.
M.D. or other

Address

651 Penny Lane

Date signed

8/22/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Rural, Williamsport Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life Time.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Rural, Williamsport Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. Williamsport Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Rhoda May Kendle

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Elvin Roy Kendle 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) MARCH 28, 1889
 8. AGE: Years 59 Months 4 Days 4 If less than one day hrs. min.
 9. Birthplace Williamsport, Washington Md.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business House Wife
 12. Name Jacob Martin Sprecher
 13. Birthplace St. James Md.
 14. Maiden name Miss Estella Stahl.
 15. Birthplace St. James Md.

16. Informant Mrs Leon Stahl
 Address R.F.D. Williamsport
 17. Burial Burial Date thereof May 5 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill.
 Location Hagerstown Md.
 18. Funeral director Edith V Leaf
 Address Williamsport Md.

19. Aug 5-48 E Lee McElroy
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2 1948 at 7 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1948, to Aug 2 1948
 and that I last saw him alive on Aug. 2 1948
 Immediate cause of death Coronary occlusion DURATION 2 hrs.
 Due to Following Fracture Thigh
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other 1/3/48
 Address Williamsport Md. Date signed 1/3/48

RECEIVED

AUG 9. 1948

BUREAU V. S.

What injury caused
fracture of hip?

Acc. fall ?

Date ?

Place ?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown R # 2
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 Years

Hospital, institution, or street address where death occurred:

Western Pike Cedar LawnHow long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown R # 2
(If outside city or town limits, write RURAL and give nearest town)Street No. Cedar Lawn
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

MARTIN LUTHER LEATHERMAN

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mary Martin6.(c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) November 2 18618. AGE: Years 86 Months 9 Days 19 If less than one day hrs. min.9. Birthplace Myersville Fred. Co. Md/
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Jacob M. Leatherman13. Birthplace Myersville Md.14. Maiden name Emmaline Gross15. Birthplace Middletown Md.16. Informant Dr. L.K. LeathermanAddress Hagerstown Md.17. Burial Date thereof 8/24/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Pauls cemeteryLocation near Clear Springs Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug. 23, 1948 Registrar Black Bowers
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1948 19 48 at 4 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/1 - 1948 10 8-21 19 48and that I last saw him alive on 1948 10 8-21 19 48Immediate cause of death chronic endocarditis DURATION 10-15
arterio. sclerosis yearsDue to chronic endocarditisDue to arterio. sclerosisOther conditions 10-15 years

(Include pregnancy within 3 months of death)

Major findings of operations chronic endocarditisAutopsy results chronic endocarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide chronic endocarditis Date of 8/21/48Where did injury occur? chronic endocarditis (City or town) (County) (State)Injured at home, farm, industry, public place (where?) chronic endocarditisMeans of injury chronic endocarditis Injured at work?23. SIGNATURE DR. VICTOR D. MILLER M. D. or other131 W. WASHINGTON, ST. 8/21-1948Address HAGERSTOWN, MD. Date signed 8/21-1948

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 25 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08715 301

1. PLACE OF DEATH:

County... Washington
 City or town... Rural Downsville
 (If outside city or town limits, write RURAL and give nearest town)
5 months
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Williamsport Rt. 1
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Rural Downsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Williamsport Rt. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Robert L. Loy

3. (b) Social Security Number

234-01-8827

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Lillian Loy
 6.(c) If alive, give age 26 years
 7. Birth date of deceased (mo., day, yr.) August 8, 1913
 8. AGE: Years 35 Months 0 Days 15 If less than one day
hrs.min.

9. Birthplace Red Cloud Neb.
 (Town, county, and state)
 10. Usual occupation Farm Laborer
 11. Industry or business Dairy Farm
 12. Name Grover C. Loy
 13. Birthplace Hayfield Va.
 14. Maiden name Anna S. Safronia
 15. Birthplace Inavale Neb.

16. Informant Mrs. Robert Loy
 Address Williamsport Rt. 1

17. Removal Aug. 24, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Hebron

Location Winchester Va.

18. Funeral director Scott F. Minnich & Son
Hagerstown Md.
 Address

19. Aug 24 19 48 E Lee McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23-48 19... at 9:15 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 23-48 19... to Aug 23-48 19...
 and that I last saw him Aug 23-48 19...
 Immediate cause of death

Acute Hemorrhage
 Due to...
 Due to...
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE A. W. Smith
Hagerstown Md.
 M. D. or other
 Address Hagerstown Md. Date signed Aug 24

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

'AUG 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08716

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
38 Charles St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 38 Charles St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lottie V. Markell
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Harry C. Markell
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 12, 1869
 8. AGE: Years 78 Months 9 Days 7 If less than one day
hrs.min.

9. Birthplace Pohersville, Maryland.
 (Town, county, and state)

10. Usual occupation House Duties

11. Industry or business

12. Name George Clopper

13. Birthplace Maryland.

14. Maiden name Keziah Holmes

15. Birthplace Maryland.

16. Informant Harry C. Markell

Address 38 Charles St.

17. Burial Date thereof Aug. 8, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown

18. Funeral director Fred W. Kraiss

Address Hagerstown

19. Aug. 7, 1948 Registrar

(Date rec'd by registrar)

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

EDT

20. DATE OF DEATH Aug 5, 1948 at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19....., to19.....

and that I last saw himalive on19.....

Immediate cause of death

Acute Coronary Occlusion

DURATION

2hr 15

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

U.S. MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE Dr. Robert Wells

Address Hagerstown, Md. Date signed Aug. 5, 48

RECEIVED

AUG 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 58 Years

Hospital, institution, or street address where death occurred:

25 S. Locust St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 25 S. Locust St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Glenna H.Matthews

3. (b) Social Security Number

214-09-0865

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Frank P. Matthews6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.)

September 25, 1891

8. AGE:

56 Years10 Months16 Days

It less than one day

.....hrs.min.

9. Birthplace

Hagerstown, Washington, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

John S. Welsh

13. Birthplace

Maryland

14. Maiden name

Nettie Boward

15. Birthplace

Maryland

16. Informant

Address

Mr. Frank P. Matthews
25 S. Locust St. Hagerstown, Md.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Date thereof August 14, 1948
(month) (day) (year)Rose HillHagerstown, MarylandW.T. NormentHagerstown, MarylandAug 13, 1948
G. H. Matthews
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 11, 1948 at 7:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 10, 1942 to Aug. 11, 1948
and that I last saw him alive on 1948

Immediate cause of death

coronary occlusion
(myocardial infarction)
hypertensive crisis
arteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

County

State

Injured at home, farm, industry, public place (where?)

Means of injury

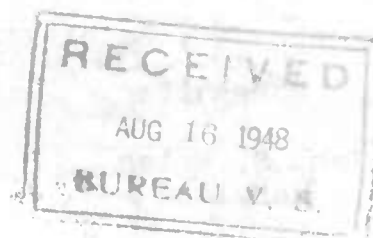
Injured at work?

23. SIGNATURE

W. Howard George
Hagerstown, Md.
M. D. of —
Date signed 8-12-48

M. D. of

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

90d

08724

Reg. Dist. No. 301

1. PLACE OF DEATH:

County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifetimeHospital, institution, or street address where death occurred:
21 S. Conococheague St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. 21 S. Conococheague St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna Mary McCardell

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife James Percy McCardell

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) Jan. 24, 1881

8. AGE:

Years

Months

Days

If less than one day

6777

hrs.

min.

9. Birthplace Williamsport, Wash., Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home

MOTHER

FATHER

12. Name Harry Collins13. Birthplace France, Europe14. Maiden name Catherine Elliott15. Birthplace Maidstone, West Virginia16. Informant F. Rollin McCardellAddress Williamsport, Md.Burial17. (Burial, cremation, or removal. Which?) Date thereof Sept. 2, 1948
(month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.Edith V. Leaf

18. Funeral director

Address Williamsport, Md.19. Sept 2 1948 E Lee McElroy
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 8/30/48 19____ al 5P. M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8/30/48 19____and that I last saw him alive on 8/30/48 19____Immediate cause of death FluoridMyocardial Disease

DURATION

1 year

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. Lee McElroy M. P. or other 8/31/48Address Williamsport, Md. Date signed 8/31/48

RECEIVED

SEP 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08725

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
Unknown
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington County Home
 How long in hospital or institution? 40 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles McCullough

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>Negro</u>	<u>Single</u>

6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 24, 1890

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>1</u>	<u>27</u>	_____ hrs. _____ min.

9. Birthplace Clearspring Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None
 12. Name John Brinkley
 13. Birthplace Unknown
 14. Maiden name Lizzie McCullough
 15. Birthplace Unknown

16. Informant Fred Long
 Address Washington County Home
 17. Burial Date thereof Aug. 22, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Wash. Co. Home
 Location Hagerstown Md.
 18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. Aug. 22, 48 Clash Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1948 at 10:45a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1948 to Aug 21 1948
 and that I last saw him alive on Aug 17 1948
 Immediate cause of death _____

	DURATION
<u>Coronary Siner</u>	<u>2 yrs.</u>
<u>Chronic glomerular nephritis</u>	<u>2 yrs.</u>
<u>Anasarca</u>	<u>1 1/2 yrs.</u>

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

SIGNATURE Ernest F. Porter
 M. D. or other _____
 Address Hagerstown Md. Date signed Aug 22 1948

RECEIVED

AUG 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 38 yrs.
 Hospital, institution, or street address where death occurred:
Washington Co. Hospital
 How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

Thomas Edward M^c Gowan

3. (b) Social Security Number

214-09-2558

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 5, 1889

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

5940

hrs.

min.

9. Birthplace Great Cacapon, Morgan Co., W. Va.

(Town, county, and state)

10. Usual occupation Shoe factory worker

11. Industry or business

FATHER

12. Name

James W. M^c Gowan

13. Birthplace

Morgan Co., W. Va.

14. Maiden name

Ellen Fitzpatrick

15. Birthplace

Morgan Co., W. Va.16. Informant Fannie B. M^c Gowan

Address

Little Orleans, Md.

17. (Burial, cremation, or removal, which?)

Date thereof

Burial Aug 9, 1948

(month) (day) (year)

Cemetery or crematory

St Patrick's Cath. Cem.

Location

Little Orleans, Md.

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19.

Aug 9, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1948 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28 - 1948 to Aug 5, 1948and that I last saw him alive on Aug 5, 1948

Immediate cause of death

art. C. Curvature
Chronic Endocarditis

DURATION

??

Due to

(?) Per Carditis

Due to

(?)

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

as above -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 8/7-48

RECEIVED

AUG 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age and birth date shown on:

FILM No. G 117 AUG 23 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

Washington Co Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Leitersburg Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. none
(If rural, give LOCATION)

2(a) If veteran, name war none

3. (a) FULL NAME

Percy Bruce Miner, Percy Bruce

3. (b) Social Security Number

173-03-0584

4. Sex MALE 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

male white Single

6. (b) Name of husband or wife none

6. (c) If alive, give age none years

7. Birth date Dec 5, 1876
deceased (mo, day, yr)

8. AGE: Years 71 Months 8 Days 98 If less than one day
71 72 8 98 hrs. min.

9. Birthplace near Leitersburg md
(Town, county, and state)

10. Usual occupation machinist

11. Industry or business

12. Name Henry Miner

13. Birthplace near Leitersburg md

14. Maiden name Leathemine Whitman

15. Birthplace Hagerstown md

16. Informant William Miner

Address Leitersburg md

17. Burial Date thereof 8-17-1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Leitersburg cemetery

Location Leitersburg md

18. Funeral director Geo B. Hoover

Address Smithsburg md

19. Aug 18, 48 Registrar G. B. Hoover

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 19 48 at 8:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 48 to Aug 14 19 48

and that I last saw him alive on Aug 14 19 48

Immediate cause of death Cerebral Hemorrhage
unobscured - general sys

DURATION

5 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Miner M. D. or other

Address Hagerstown Md Date signed 8/15/48

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

08728

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 YEARS
 Hospital, institution, or street address where death occurred:
INTERVALE STREET
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Intervale Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Clifford Mc. Misner

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 8. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) February 4, 1904
 8. AGE: Years 44 Months 6 Days 5 If less than one day
 hrs. min.

9. Birthplace Garfield, Maryland.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business

FATHER 12. Name Dallas W. Misner
 13. Birthplace Garfield, Maryland.
 MOTHER 14. Maiden name Rosie C. Green
 15. Birthplace Garfield, Maryland.

16. Informant Mrs. Dallas Misner
 Address Intervale Street, Hagerstown, Md.

17. Burial Aug. 12, 1948
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Bethel Cemetery
 Location Near Garfield, Maryland.

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland.

19. Aug. 10, 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

Aug/9/48

EDT

3:30P

20. DATE OF DEATH 19 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 20, 1948 to
 and that I last saw him alive on Aug/3/48

Immediate cause of death

DURATION

Influenza arthritis 10yrs
 Due to chr. valvular myocardial
heart disease ?
 Due to auricular fibrillation ?
 Other conditions acute ventricular fibrillation

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide no Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Robert Wells, M.D.
Hagerstown, Md. M. D. or other
 Address Aug. 10-48 Date signed

RECEIVED

AUG 12 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH

County Washington
City or town Rural, Boonsboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

Fahney Memorial Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Fredrick

City or town Lewisport
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

William Mohler

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 3 - 1854

8. AGE:

Years 94

Months 4

Days 11

If less than one day

hrs.

min.

9. Birthplace

Utica, Fred
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Farm Laborer
Andrew Mohler

FATHER

12. Name

Andrew Mohler

13. Birthplace

md.

MOTHER

14. Maiden name

Sophie Mc Cormick

15. Birthplace

md.

16. Informant

Fahney Memorial Home
Boonsboro - Md

17.

Funeral Date thereof Aug 17, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory

Utica Reformed

Location

Utica, Fred Co. Md.

18. Funeral director

B. V. Creager & Co.
Thurmont Md.

19.

Aug 14, 1948 John H. Baird
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 48 at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 19 48 to August 14 19 48

and that I last saw him alive on August 12 19 48

Immediate cause of death

Chronic Myocarditis.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

GW Swan M.D. M. D. or other
Boonsboro Address Date signed 8/14/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

08729

93d

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08730

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 25 years
 Hospital, institution, or street address where death occurred:
 510 Salem Avenue
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland..... County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 510 Salem Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

John P. Mumaw

 3. (b) Social Security Number
 719-05-5477

4. Sex..... Male..... 5. Color or race..... White..... 6. (a) Single, married, widowed, or divorced..... Single.....
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... July 24, 1881.....
 8. AGE: Years..... 67..... Months..... 0..... Days..... 9..... It less than one day..... hrs. min.
 8. (c) If alive, give age..... years

9. Birthplace..... Harrisonburg, Virginia
 (Town, county, and state)
 10. Usual occupation..... Railroad Conductor
 11. Industry or business..... N.W. Railroad
 12. Name..... Wm. H. Mumaw Sr.
 13. Birthplace..... Virginia
 14. Maiden name..... Mattie M Adams
 15. Birthplace..... Virginia
 16. Informant..... W. H. Mumaw
 Address..... Baltimore, Maryland
 17. Burial..... Date thereof..... 8-5-48
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Maryland
 18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland
 19. Aug 4, 1948..... Registrar
 (Date rec'd by registrar).....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 8.2.48..... 19..... at..... M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 7.1.47..... 19..... to 8.2.48..... 19.....
 and that I last saw him alive on 8.1.48..... 19.....
 Immediate cause of death..... Progressive Muscular Atrophy.....
 DURATION..... 1 yr.
 Due to.....
 Due to.....
 Other conditions..... Congestive heart failure. 1mo.
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... Hagerstown, Md.
 M. D. or other.....
 Date signed..... 8.3.48

RECEIVED

AUG 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

08731

164 C

1. PLACE OF DEATH:

County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
213 S. Artizan St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 213 South Artizan St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

George Clinton Murray

3. (b) Social Security Number

215-09-7434

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1886

8. AGE: Years 61 Months 10 Days 18 If less than one day
 hrs. min.

9. Birthplace Williamsport, Wash., Maryland
 (Town, county, and state)

10. Usual occupation Laborer
 11. Industry or business Byron's Tannery

MOTHER FATHER
 12. Name John Murray
 13. Birthplace Williamsport, Md.

14. Maiden name Sarah Miller
 15. Birthplace Williamsport, Md.

16. Informant Percy Murray
 Address Williamsport, Md.

17. Burial Date thereof Aug. 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery
 Location Williamsport, Md.

18. Funeral director Edith V. Leaf
 Address Williamsport, Md.

19. Aug 27 1948 E. Lee M. Elroy
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 27-48 1948 to Aug 27-48 1948
 and that I last saw him alive on Aug 27-48 1948

Immediate cause of death

DURATION

Gunshot wound of chest instant death
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

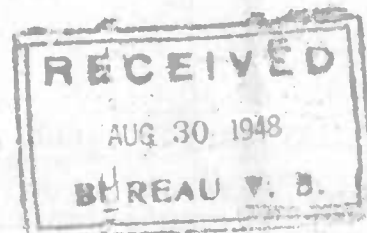
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Aug 27-48

Where did injury occur? Williamsport (City or town) Washington (County) Md (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury gunshot (self-inflicted)23. SIGNATURE E. Lee M. Elroy M. D. or otherAddress Williamsport, Md Date signed Aug 27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life expect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

192

08732

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 Day
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Devonshire Road
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Elsie Caroline Ocker

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 16, 1934
 6.(c) If alive, give age..... years

8. AGE: Years 13 Months 9 Days 28 If less than one day
 hrs. min.

9. Birthplace Hagerstown Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Student

11. Industry or business.....

12. Name John J. Ocker13. Birthplace Hagerstown Md.14. Maiden name Helen Pownell15. Birthplace Romney W. Va.16. Informant John J. OckerAddress Hagerstown Md.

17. Burial Date thereof 8/17/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Oct. 16, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

4:25

2D. DATE OF DEATH Aug. 14, 1948 EDT 19..... at..... A..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

Extensive 2nd & 3rd degree

Due to burns to face

abdomen

Due to Upper & lower extremities

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... no

Date of op.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/12/48Where did injury occur? Hagerstown Wash. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury lightening struck Injured at work? No

DEPUTY MEDICAL EXAMINER

WASH. CO., MD.

23. SIGNATURE S. Robert WellsAddress Hagerstown, Md. Date signed Aug. 14, 1948

RECEIVED

AUG 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08733 73a 2a3

1. PLACE OF DEATH:

County WashingtonCity or town Rural Hazletstown

(If outside city or town limits, write RURAL and give nearest town)

How long is above place of death?

Hospital, institution, or street address where death occurred:

Intensive Nursing Home

How long in hospital or institution?

no.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County DauphinCity or town Lights town

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Engine Oden

3. (b) Social Security Number

none

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

?

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Apr 24 1870

8. AGE:

Years

Months

Days

If less than one day

78320

hrs.

min.

9. Birthplace

Wellsboro Md

(Town, county, and state)

10. Usual occupation

Rethed Sheet metal worker

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

14. Maiden name

Elizabeth Richardson

15. Birthplace

unknown

16. Informant

Wiles B Zimmerman

Address

Lights town Pennsylvania

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 17 1948

Cemetery or crematory

Willow Grove Cemetery

Location

Lights town Pennsylvania

18. Funeral director

McIntire & Sons

Address

Hazletstown Maryland

19.

(Date rec'd by registrar)

Aug 14 1948David M. Fisher

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1948 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 11 1948 to Aug 14 1948and that I last saw him alive on Aug 13 1948

Immediate cause of death

DURATION

Pernicious Anemia 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE David P. Brewer M.D.

M. D. or other

Address Clear Spring Md Date signed Aug 14 1948

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 31 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Keadle

08734

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Mos.

Hospital, institution, or street address where death occurred:

338 Liberty St.How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 338 Liberty St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

MRS CLARA POFFENBERGER

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow6. (b) Name of husband or wife William6. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) March 31 18548. AGE: Years Months Days If less than one day
94 4 14 hrs. min.9. Birthplace Boonsboro Wash. co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name William Cleland13. Birthplace Bunker Hill W. Va.14. Maiden name Malinda Fritz15. Birthplace Boonsboro Md.16. Informant Mrs. Effie HoffmanAddress Hagerstown Md.17. Burial Date thereof 8/17/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug. 16, 1948 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948 at 3:35P M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~on August 15, 1948 to 1948and that I last saw him alive on August 15, 1948Immediate cause of death Pulmonary edema

DURATION

48-72hoursDue to Chronic heart failure sameDue to Arteriosclerotic heart disease ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert F. Keadle M. D. or otherAddress 132 W. Wash St. Date signed 8-15-48Hagerstown Md

RECEIVED

AUG 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

08735

302

1. PLACE OF DEATH

County..... WashingtonCity or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 53 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... WashingtonCity or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Homer Clayton Rager

3. (b) Social Security Number

214-09-17374. Sex..... male5. Color or race..... white6. (a) Single, married, widowed, or divorced..... married6. (b) Name of husband or wife..... Daisy Rager7. Birth date of deceased (mo., day, yr.)..... June 22, 18956. (c) If alive, give age..... 49 years8. AGE: Years..... 53 Months..... 2 Days..... 5 If less than one day..... hrs. min.9. Birthplace..... Hagerstown, Wash. Co., Md.

(Town, county, and state)

10. Usual occupation..... Brenner Lyon & Co.11. Industry or business..... Junk Dealers12. Name..... Phillip Rager13. Birthplace..... Johnstown, Penna.14. Maiden name..... Rose Rhodes15. Birthplace..... Johnstown, Penna.16. Informant..... Mrs. Daisy RagerAddress..... Hagerstown, Md.17. burial Date thereof..... 9-31-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill GemeteryLocation..... Hagerstown, Md.18. Funeral director..... Scott F. Minnich & SonAddress..... Hagerstown, Md.19. Aug. 31 19 48 Phillip Rager

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 27 - 48 at Home

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 27 - 48 19..... to Aug 27 - 48 19.....and that I last saw him/her on Aug 27 - 48 19.....

Immediate cause of death.....

DURATION

Ch. Alcoholic 12 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... J. SW Lutz

M. D. or.....

Address..... Hagerstown, Md. Date signed..... 9-30-48

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1948

BUREAU V. S.

~~RECEIVED~~

SEP 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Years
 Hospital, institution, or street address where death occurred:
2422 Virginia Ave
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2422 Virginia Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

PERCY DOYLE RHODES

3. (b) Social Security Number

220-10-3878

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Bertha Brewer
 7. Birth date of deceased (mo., day, yr.) January 31 1881 6.(c) If alive, give age 64 years
 8. AGE: Years 67 Months 6 Days 11 If less than one day --- hrs. --- min.

9. Birthplace Clear Springs Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Maintenance Dept.
 11. Industry or business Fairchild Air Craft
 12. Name Dallas Rhodes
 13. Birthplace Clear Spring Md.
 14. Maiden name Sophia Moore
 15. Birthplace Clear Spring Md.

16. Informant Mrs. Bertha R. Rhodes
 Address Hagerstown Md.
 17. Burial Date thereof 8/14/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Pauls cemetery
 Location near Clearspring Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Aug. 13, 1948 Registrar Bertha Brewer
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1948 at 5.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to Aug 11 1948
 and that I last saw him alive on August 19 1948

Immediate cause of death Coronary Thrombosis
 DURATION 5 hrs

Due to

Due to

Other conditions Premature atherosclerosis coronary thrombosis onset 2 1/2 mo and 9 days preceding fatal attack
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Layman, M.D.Address Hagerstown Md Date signed 11 Aug 1948

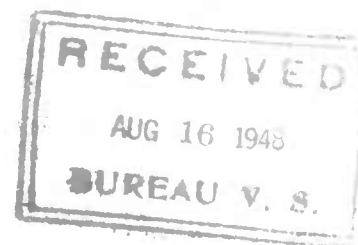
M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



M

32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926

08737

Reg. Dist. No. 386

1. PLACE OF DEATH:

County WashingtonCity or town Blue Ridge Summit, Penna.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Blue Ridge Summit, Penna.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Frances Noble Rock

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Daniel Hill Rock7. Birth date of deceased (mo., day, yr.) June 10, 1980 6. (c) If alive, give age 64 yrs.8. AGE: Years Months Days It less than one day
68 2 14 _____ hrs. _____ min.9. Birthplace Water Side, Pennsylvania
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John Irvine Noble13. Birthplace Water Side, Pennsylvania14. Maiden name Nancy Carper15. Birthplace Water Side, Pennsylvania16. Informant D.H. RockAddress Blue Ridge Summit, Pennsylvania17. Burial Date thereof August 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union CemeteryLocation Fairfield, Penna.18. Funeral director S. L. AllisonAddress Fairfield, Penna.19. Aug 26 19 48 Geo. H. Ferguson
(Date used by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24th 19 48 at 6:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 22nd 19 48 to Aug 24th 19 48and that I last saw him alive on Aug. 22nd 19 48Immediate cause of death Coronary occlusion DURATIONDue to Fatty degeneration of heart with mitral insufficiency 2 to 3 yrs.Due to insufficiency

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Geo. H. Ferguson M. D. or otherAddress Blue Ridge Summit, Pa. Date signed Aug 24th

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08738 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
438 North Mulberry Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 438 North Mulberry Street
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Jacob Sayles

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower

8. (b) Name of husband or wife Jennie Sayles

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1857

8. AGE: Years Months Days If less than one day
91 2 1 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Retired Policeman

11. Industry or business

FATHER 12. Name Thomas Sayles

13. Birthplace Hagerstown, Maryland

MOTHER 14. Maiden name Katherine Miller

15. Birthplace Hagerstown, Maryland

16. Informant Mrs. Lillian Rudy

Address Hagerstown, Maryland

17. Burial Date thereof 8-15-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Aug 14, 19 48 Phas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13, 19 48, at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 19 43, to Aug 13, 19 48

and that I last saw him alive on Aug 12, 19 48

Immediate cause of death

Congestive Heart Failure

Due to arteriosclerotic Cardiovascular disease

Due to generalized arteriosclerosis

Other conditions Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert H. Bowers M.D.

154 W. Washington St. M. D. or other

Address Hagerstown, Md. Date signed 8/13/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 36 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 60 E. Franklin St.
 (If rural, give LOCATION)
 2. (a) if veteran, name war _____

3. (a) FULL NAME

Wayne A. Sellman

3. (b) Social Security Number

220-10-3011

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Frances L. Sellman6. (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.)

Nov November 1, 1911

8. AGE:

Years

36

Months

9

Days

3

If less than one day

..... hrs. min.

9. Birthplace

Hagerstown Wash. Md.

(Town, county, and state)

10. Usual occupation

Detective

11. Industry or business

Hag. Police Dept.

FATHER

12. Name

William A. Sellman

MOTHER

13. Birthplace

Mt. Airy Md.

14. Maiden name

Maude Beck

15. Birthplace

Hagerstown Md.

16. Informant

Mrs. Frances Sellman

Address

Hagerstown Md.

17. Burial

Date thereof Aug. 7, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19.

Aug. 7, 1948

(Date reg'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1948 11:15p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 41 1941 to Aug 4 1948and that I last saw him alive on Aug 4 1948

Immediate cause of death

DURATION

Vascular hypertension?Due to chr. glomerular nephritis10y rscoronary occlusion34mo sDue to cirrhosis of liver5mo sOther conditions P due to C.P.C.4mosPleural effusion (R)

(Include pregnancy within 8 months of death)

Major findings of operations Acute ventricular fibrillation

Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE S. Robert & Wells, Jr. D.

M. D. or other

Address Hagerstown, Md. Date signed Aug. 6, 1948

RECEIVED

AUG 11. 1948

BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr, Hornbaker

08740

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 YearsHospital, institution, or street address where death occurred:
1801 Virginia Ave.How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1801 Virginia Ave.
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

MRS SUSAN CATHERINE SHEWERIDGE

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Williard F. Shewbridge6. (c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) December 23, 1860

8. AGE:

Years

Months

Days

If less than one day

8755

hrs.

min.

9. Birthplace Keedysville, Washington Co., Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Calvin C. Valentine13. Birthplace Myersville Md.14. Maiden name Mary Ann Gouff15. Birthplace Rohersville, Md.16. Informant Mrs Fred LudwigAddress Hagerstown Md.17. Burial Date thereof 8/10/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Harpers CemetaryLocation Harpers Ferry West Virginia18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug. 10, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 19 48, at 9 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-1948 to 8-8-1948and that I last saw her alive on 7-28-1948

Immediate cause of death

Tuberculous meningitis

DURATION

5 weeks

Due to

Other condition Generalized arteriosclerosis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

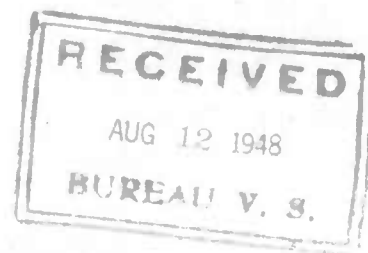
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John N. Hornbaker M.D.

154 W. Washington St. M. D. or other

Address Hagerstown, Md. Date signed 8-9-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

306

1. PLACE OF DEATH:

County... Washington
City or town... Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 4 days
Hospital, institution, or street address where death occurred:
Ritchie Hospital
How long in hospital or institution? 5 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Anne Arundel
City or town... South River
(If outside city or town limits, write RURAL and give nearest town)
Street No. Anne Arundel County Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ALLEN SHIPLEY

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Elizabeth Roseanna Wade 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 18, 1875
8. AGE: Years 73 Months 3 Days 21 If less than one day hrs. min.

9. Birthplace Elkridge, Howard County, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Allen Shipley
13. Birthplace Elkridge, Howard County, Maryland
14. Maiden name Harriett Lemartin
15. Birthplace Anne Arundel County, Maryland

16. Informant Allen Shipley (The deceased)
Address Ritchie Hospital, Cascade, Md.

17. Buried Date thereof Aug 10 - 48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematorium Landon Park
Location Fredrick R. d.

18. Funeral director Edward Foulson
Address 2359 W. 4th St.

19. Aug 29 x 8 ASW Hedrick
(Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 19 48 at 7:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 48 to August 8 19 48
and that I last saw him alive on August 7 19 48

Immediate cause of death Respiratory failure

Due to infection DURATION 5 months

Due to Carcinoma of skin of face more than 5 months

Other conditions Rheumatic heart disease, Arteriosclerosis, Rt. inguinal hernia
(Include pregnancy within 3 months of death)

Major findings at operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert A. Moses, M.D.
Address Ritchie Hospital, Cascade, Md. Date signed Aug 8, 1948

MARGIN RESERVED FOR BINDING

I

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08741

53 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Washington County
 City or town Hagerstown Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital

Now long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Clearspring Maryland RFD #2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Clearspring Md. RFD #2
 (If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Jacklin Lovone Shoemaker

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Baby

6.(b) Name of husband or wife Baby

7. Birth date of deceased (mo., day, yr.) 7-8-48 6.(c) If alive, give age 0 years

8. AGE: Years 1 Months 2 Days 0 It less than one day 0 hrs. 0 min.

9. Birthplace Clearspring Washington Md.
 (Town, county, and state)

10. Usual occupation Baby

11. Industry or business

12. Name Jessie Shoemaker

13. Birthplace Handcock Maryland

14. Maiden name Dorothy Mummert

15. Birthplace Clearspring Maryland

16. Informant Mrs. Dorothy Mummert Shoemaker

Address Clearspring Maryland RFD #2

17. Burial Date thereof Aug. 20 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Cemetery

Location Near Clearspring Md.

18. Funeral director Edith V. Leaf

Address #7 Church St. Williamsport, Md.

19. Aug. 20 1948 Registrar Pharrell Bowser
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 August 1948 at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 August 1948, to 19 August 1948 and that I last saw him alive on 19 August 1948

Immediate cause of death Congenital Hydrocephalus DURATION 1 Month

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

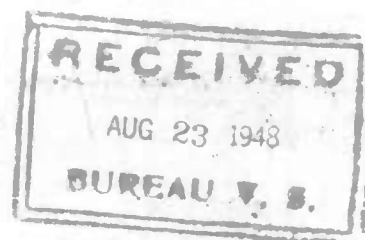
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest R. Brown M.D.

Address Wash. G. Hospital Date signed 8/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

620 N. Mulberry St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 620 N. Mulberry St
 (If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

Anna M. Schrader

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife

6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Mar. 18th 1871

8. AGE: Years Months Days If less than one day
77 4 26 hrs. min.

9. Birthplace Franklin Co. Pa.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Jasper N. Sheely

13. Birthplace Franklin Co. Pa.

14. Maiden name Maria Plummer

15. Birthplace Washington Co. Md

16. Informant Mrs. John B. Kofly

Address 620 N. Mulberry St. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/48
 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Greencastle, Pa.

18. Funeral director C. L. Sumner

Address Hagerstown Md.

19. Aug 15, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14, 1948 at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12, 1948 to Aug. 14, 1948
 and that I last saw him alive on June 2, 1948

Immediate cause of death acute myocardial infarction

Due to acute Dea...

Due to arteriosclerosis

Other conditions Found dead in bed this AM.

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X X X Date of —

Where did injury occur? X X X (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE W. Howard George

Address Hagerstown, Md. M. D. or other —

Date signed Aug 14, 48

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Earl Young

08744

932

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 YearsHospital, institution, or street address where death occurred:
422 Summit Ave.How long in hospital or institution? 00--

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 422 Summit Ave.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

MRS EMMA KATHER SPRECHER

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife William H. Sprecher6. (c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) February 4, 18678. AGE: Years 81 Months 6 Days 0 If less than one day --- hrs. --- min.9. Birthplace Cearfoss, Washington Co. Md.
(Town, county, and state)10. Usual occupation House Wife11. Industry or business Own Home12. Name Joseph E. Neibert13. Birthplace Hagerstown Md.14. Maiden name Marie Alice Horine15. Birthplace Hagerstown Md.16. Informant Mrs. Charles AlvordAddress Hagerstown Md.17. Burial Date thereof 8/6/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Aug 5, 48 Phanth Bowers
(Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1948, at 6 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1/47 19--- to 8/4/48 19---and that I last saw him alive on 8/3/48 19---Immediate cause of death Congestive Heart Failure DURATION 4 mosDue to Chronic SclerosisOther conditions 10/4/48

(Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---Autopsy results ---

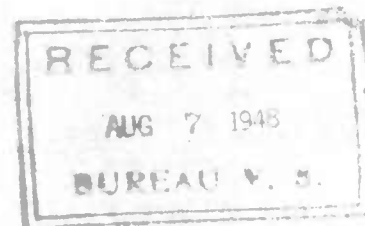
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE Phanth Bowers M. D. or other ---Address Hagerstown Md. Date signed 8/4/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08745

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place at death? 60 years
 Hospital, institution, or street address where death occurred:
32 South Potomac Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 32 South Potomac Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Alvin P. Stauffer

3. (b) Social Security Number

NONE

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lizzie H. Stauffer
 6. (c) If alive, give age 82 years
 7. Birth date of deceased (mo., day, yr.) December 27, 1856
 8. AGE: Years 91 Months 7 Days 7 If less than one day hrs. min.

9. Birthplace Goodsville, Lancaster Co., Pa.
 (Town, county, and state)

10. Usual occupation Doctor of Medicine

11. Industry or business

12. Name Isaac W. Stauffer
 13. Birthplace Lancaster, Pa.
 14. Maiden name Evaline Kurtz
 15. Birthplace Lancaster, Pa.

16. Informant Mrs. Alvin P. Stauffer
 Address Hagerstown, Maryland

17. Cremation Date thereof Aug. 4 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Aug 4, 1948 Registrar Chas. Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1948 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1948 to Aug. 3, 1948
 and that I last saw him alive on Aug. 2, 1948

Immediate cause of death Generalized arterio-sclerosis
 DURATION 7 yrs -

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, term, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Stauffer - M.D.
 Address Hagerstown, Md Date signed Aug. 3, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

AUG 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08746

Reg. Dist. No. 316

1. PLACE OF DEATH:

County Washington
 City or town Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mary Elizabeth Stevens

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Clarence Cook Stevens
 6. (c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) March 14, 1885
 8. AGE: Years 63 Months 5 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Mercersburg-Franklin-Penna
 (Town, county, and state)
 10. Usual occupation Home Duties
 11. Industry or business _____

FATHER 12. Name Unknown
 13. Birthplace _____
 MOTHER 14. Maiden name _____
 15. Birthplace _____

16. Informant Clarence C. Stevens
 Address Keedysville, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug. 24, 1948
 (month) (day) (year)
 Cemetery or crematory St. Paul
 Location Western Pike--Route 40

18. Funeral director R. I. Earnshaw
 Address Keedysville, Md

19. (Date rec'd by registrar) Aug 23 1948 Registrar Robt. G. [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1948 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1946 to Aug 20 1948
 and that I last saw her alive on Aug 19 1948

Immediate cause of death Cerebral Hemorrhage DURATION 8 days
Arteriosclerosis and
hypertension 3 yrs. +

Due to _____
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

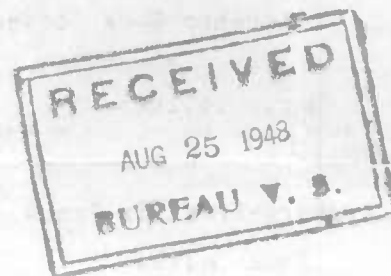
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter H. Shealy M.D. M. D. or other _____Address Sharpsburg, Md Date signed 8/21/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Hours
Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 12 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural--Williamsport
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD #1 Williamsport
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Roy James Stout

3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
-----------------------	----------------------------------	---

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 28, 1887
6. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>3</u>	<u>2</u> hrs. min.

9. Birthplace Near Downsville, Wash., Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Otho J. Stout

13. Birthplace Do not know

14. Maiden name Rebecca Dick

15. Birthplace Do not know

16. Informant Mr. Arthur Cunningham
Address Williamsport, Md. RFD# 1

17. Burial Date thereof Sept. 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview Cemetery

Location Williamsport, Md.

18. Funeral director Edith V. Leaf

Address Williamsport, Md

19. Sept. 4, 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/48 19..... at 12:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/21/48 19..... at 8/31/48 19.....

and that I last saw him alive on 8/31/48 19.....

Immediate cause of death Cerebral
hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: It death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. F. Young

Address Williamsport, Md. Date signed 8/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 8 1948

BUREAU V. S.

RECEIVED

AUG 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 days

3. (a) FULL NAME

JAMES H. C. WELLER

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Hilda

7. Birth date of deceased (mo., day, yr.)

May 1, 1893

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

55328

hrs.

min.

9. Birthplace

Mercersburg, Franklin Co., Pa.

(Town, county, and state)

10. Usual occupation

Handy man

11. Industry or business

Bakery

FATHER

12. Name

Joseph Weller

13. Birthplace

Mercersburg, Pa.

MOTHER

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Miss Carrie

Address

Greencastle, Pa.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

9/1/48

(month) (day) (year)

Cemetery or crematory

Browns Mill

Location

Franklin Co., Pa.

18. Funeral director

A. E. Minnich

Address

Greencastle, Pa.

19.

Aug. 30, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County FranklinCity or town R.D. #1, Greencastle

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

non-vet

3. (b) Social Security Number

183-10-2231

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29-48 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 29-48 19. Aug 29-48 19.and that I last saw him Aug 29-48 19.

Immediate cause of death

DURATION

Saw poisoning by
one of the Baptists
and group5 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

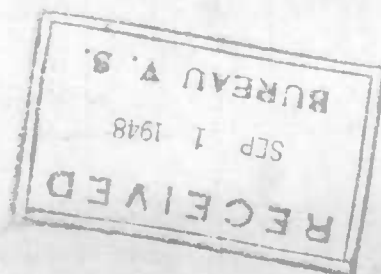
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed Aug 30, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:

Washington Co. Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederick
 City or town Woodstock Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Christina S. Stetzel

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Jacob H. Stetzel

7. Birth date of deceased (mo., day, yr.)

Oct. 31, 18696.(c) If alive, give age. 81 years

8. AGE:

Years

Months

Days

If less than one day

7893

hrs.

min.

9. Birthplace

Frederick Co. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name

Anthony Smith

13. Birthplace

Frederick Co. Md.

14. Maiden name

Susan Phippen

15. Birthplace

Frederick Co. Md.

16. Informant

William M. Stetzel

Address

20 Stafford White Plains, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Aug. 8, 1948
(month) (day) (year)

Cemetery or crematory

Rocky Hill

Location

near Woodstock Md.

18. Funeral director

Burwell & Hartzler

Address

Woodstock Md.

19. Aug. 6, 1948

(Date rec'd by registrar)

G. H. Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 19 48 at 10:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 48 to August 4 19 48and that I last saw her alive on August 4 19 48

Immediate cause of death

Chronic Arteriosclerotic Kidney Disease

DURATION

10 yrs

Due to

Arteriosclerosis, General25 years

Due to

Other conditions

Diabetes Mellitus, mild6 months

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

Chr. Nephritis, Arteriosclerosis, Mesenteric Thrombosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dalton M. West
M. D. or other

Address

Hagerstown Maryland

Date signed

8-5-48

RECEIVED

AUG 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Wagertown Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County Franklin

City or town Greencastle
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 247 So Washington
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Melancton Santee Williams

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Lucy Williams

6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1886

8. AGE: Years 61 Months 9 Days - If less than one day
 hrs. - min. -

9. Birthplace Washington Co Md
 (Town, county, and state)

10. Usual occupation Self

11. Industry or business Baker

12. Name Telghman W. Williams

13. Birthplace Md

14. Maiden name Anna Reese

15. Birthplace Md

16. Informant Lucy Williams

Address Greencastle Pa

17. Burial Date thereof Aug 18, 48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Calvary Hill

Location near Greencastle

18. Funeral director A. E. Murrish

Address Greencastle Pa

19. Aug. 17, 48 BlackBowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 15, 1948 at 6:35 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 14, 1948 to Aug 15, 1948

and that I last saw him alive on Aug 15, 1948

Immediate cause of death Unruptured (subarachnoid) hem-

orrhage of undetermined origin

Due to 1 wk

Due to

Due to

Other conditions Arterio-sclerotic

heart disease; hypertensive

(Include pregnancy within 3 months of death)

Cardio-vascular disease

Major findings of operations

Date of op. congestive

Autopsy results subarachnoid hemorrhage, heart.

PHYSICIAN: Please underline the cause to which death should be charged statistically failure

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. D. Stauffer - W. D.

Address Wagertown, Md M. D. or other Aug 15, 1948

Date signed

RECEIVED

AUG 19 1948

BUREAU V. S.

08752

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 Dr. Bowman

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Washington Co. Hosp.How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 15 Greenfield Rd.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Unnamed child of D Earl Wolf Jr.

3. (b) Social Security Number

None4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife -----7. Birth date of deceased (mo., day, yr.) Aug. 24 1948 6. (c) If alive, give age --- years8. AGE: Years 0 Months 0 Days 1 If less than one day --- hrs. --- min.9. Birthplace Hag. Wash. Co. Md.
(Town, county, and state)10. Usual occupation None11. Industry or business -----12. Name D Earl Wolf Jr.13. Birthplace Hagerstown Maryland14. Maiden name Gladys Hendricks15. Birthplace Washington, D. C.16. Informant D Earl Wolf Jr.Address 15 Greenfield Rd. Hagerstown Md.17. Burial Date thereof Aug 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Maryland18. Funeral director Andrew K CoffmanAddress Hagerstown Maryland19. Aug 27, 1948 Blackbeavers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 19 48, at 10P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/24 19 48, to 8/25 19 48, and that I last saw him alive on 8/25 19 48Immediate cause of death AbortionDue to prematurityDue to -----Other conditions -----

(Include pregnancy within 8 months of death)

Major findings of operations ----- Date of op. -----Autopsy results Abortion
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Dr. Bowman M. D. or other MDAddress Hagerstown, Md. Date signed 8/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 30 1948

BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 24 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... 223 Vermont St. Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Charles Percy Zimerly

3.(b) Social Security Number

228-16-1963

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May II 1884
 8. AGE: Years 64 Months 2 Days 7 If less than one day
hrs. min.

9. Birthplace Williamsport Washington Md.
 (Town, county, and state)
 10. Usual occupation Labor.
 11. Industry or business Labor.
 12. Name John A Zimerly
 13. Birthplace Cumberland Md.
 14. Maiden name Annie M Long,
 15. Birthplace Williamsport Md.

16. Informant Mr. George Zimerly
 Address 223 Vermont . Williamsport
 17. Burial Date thereof Aug. 21 1948.
 (Burial, cremation, or removal. Which?) (Month) (day) (year)
 Cemetery or crematory Riverview .
 Location Williamsport Md.
Edith V Leaf.
 18. Funeral director
 Address Williamsport Md.

19. Aug. 19. 19 48 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

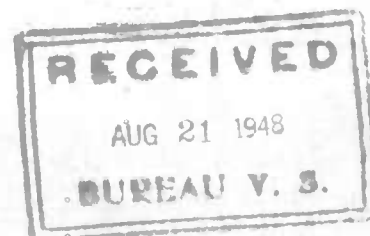
20. DATE OF DEATH 8/18/48 19... at 7:25 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/48 19... to 8/18/48 19...
 and that I last saw him alive on 8/17/48 19...
 Immediate cause of death Coronary Disease DURATION 6 mo.
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE C. F. Green M. D. or other
 Address Williamsport Md. Date signed 8/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

08754

97

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTON

City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

WASHINGTON COUNTY HOSPITAL

How long in hospital or institution? 13 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA County FRANKLIN

City or town GREENCASTLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. RIDGE AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HARVEY MELVIN ZIMMERMAN

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

SINGLE Divorced

6.(b) Name of husband or wife Hilda Goodwin

7. Birth date of deceased (mo., day, yr.) APRIL 5 1883

6.(c) If alive, give age.....years

8. AGE: Years 65 Months 3 Days 26.....hrs.min.

9. Birthplace Welsh Run, PENNA.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business Farm

12. Name Oscar Zimmerman

13. Birthplace Welsh Run

14. Maiden name Mary Jamison

15. Birthplace Middleburg Pa

16. Informant C. F. Zimmerman

Address Greencastle Pa

17. B Date thereof Sept 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location near Greencastle

18. Funeral director R. B. Wmumich

Address Greencastle Pa

19. Aug 31, 1948 Registrar Shasthowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Aug 19 48 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 Aug 19 48 to 31 Aug 19 48

and that I last saw him alive on 30 Aug 19 48

Immediate cause of death Shock,
hemorrhage, DURATION 1 day

Due to Hemorrhage from colonic
ulceration 3 days

Due to Dysentery unknown

Other conditions concomitant chronic
conspicuous hypotrophy
(Include pregnancy within 9 months of death)

Major findings of operations.....

Autopsy results ulcerative colitis & hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Samuel Brown M.D.

Address Washington G. Hosp Date signed 31 Aug 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1948

BUREAU V. S.